aetna®

# Employee Enrollment/Change Request
## Aetna Health of California Inc.

**TO COMPLY WITH CALIFORNIA LAW WHEREVER THE TERM "SPOUSE" APPEARS IT SHALL BE CONSTRUED TO INCLUDE DOMESTIC PARTNER.**

**Coverage is provided by Aetna Health of California Inc.**

***Instructions:*** *Refer to the instructions on the back before completing this form. You must complete this application in full or it will be returned to you resulting in a delay in processing. You are solely responsible for its accuracy and completeness.*

| Control | Suffix | Account | Plan Number |
|---|---|---|---|
| Group Number | | | Class Code |

**Employer Group Information (To Be Completed by Employer)**

**Group/Employer Name – Full Name of Business or Organization**

### A. Type of Activity – Employee Completes Sections A – E. *Please Print Clearly.*

**Enrollment**
☐ New Enrollee/Subscriber

**Effective Date:** ____/____/____

**Date of Hire:** ____/____/____

**Change** – *Check all that apply.*
☐ Add Spouse
☐ Add Dependent Child
☐ Name Change
☐ Other _____
☐ Change Plan: _____
☐ Control/Suffix/Acct/Plan: _____

**Date of Event:** ____/____/____

**Reason:** _____

**Remove or Terminate** – *Check all that apply.*
☐ Remove Spouse
☐ Remove Dependent Child
☐ Employee Withdrawal/ Termination

**Effective Date:** ____/____/____

**Reason:** _____

**Continuation of Coverage, i.e., COBRA, Cal-COBRA -** *Not all options are available. Contact Employer for available options.*
**Coverage for:** ☐ Employee ☐ Dependents
**Length of Continuation (months):**
☐ 18 ☐ 36 ☐ Other ____
☐ 29 – Attach disability determination from the Social Security Administration

**Date of Loss of Coverage:** ____/____/____

**Date of Qualifying Event:** ____/____/____

**Continuation of Coverage Expiration Date:** ____/____/____

### B. Employee Information

| Social Security Number | Last Name, First Name, M.I. | | Home Telephone |
|---|---|---|---|
| Home Address | Apt. No. | City, State | ZIP Code |
| Employer Name | | | Work Telephone |
| Work Address | | City, State | ZIP Code |

### C. Plan Options – Your selection(s) must be offered by your employer.

| | | | Indicate Plan Name | Primary Copay |
|---|---|---|---|---|
| ☐ HMO | ☐ QPOS® | ☐ HMO Deductible Plan | | ☐ $5 ☐ $10 |
| ☐ Aetna HealthFund® HMO (HRA) | | ☐ Aetna Value Network | | ☐ $15 ☐ Other $ _____ |
| ☐ Vitalidad Plus℠ California con Aetna | | ☐ Vitalidad Mexico con Aetna℠ | | |

While the Federal Patient Protection and Affordable Care Act generally mandates coverage of dependent children up to age 26, your plan may allow coverage beyond age 26. Please refer to your plan documents or contact your benefits administrator.

### D. Individuals Covered - *List individuals for whom you are enrolling or adding/changing/removing coverage.*
***Provide details for "Yes" responses below.***

| (A)dd (C)hange ____ (R)emove | 1. Employee Name (Last, First, M.I.) | Sex (M/F) | Birthdate (MM/DD/YYYY) / / |
|---|---|---|---|

| Social Security Number | Other Medical Coverage Yes* ☐ | Other Rx Drug Coverage Yes* ☐ | Physically or Mentally Disabled N/A | Primary Medical Office ID Number | Current Patient Yes ☐ |
|---|---|---|---|---|---|
| | | | | | |

*Continued on Page 2*

***Employee copy may be used as a temporary ID card for 30 days from the effective date if authorized by employer. Coverage must be verified with Aetna prior to visiting a specialist or admission to a hospital.***

**D. Individuals Covered – (continued)** ***List individuals for whom you are enrolling or adding/changing/removing coverage.***
****Provide details for "Yes" responses below.***

| (A)dd (C)hange ____ (R)emove | **2. Spouse Name** (Last, First, M.I.) | Sex (M/F) | **Birthdate** (MM/DD/YYYY) / / |
|---|---|---|---|

| **Social Security Number** (if dependent has no SSN, write "None") | Other Medical Coverage **Yes*** ☐ | Other Rx Drug Coverage **Yes*** ☐ | Physically or Mentally Disabled **Yes** ☐ | Primary Medical Office ID Number | Current Patient **Yes** ☐ |
|---|---|---|---|---|---|

| (A)dd (C)hange ____ (R)emove | **3. Child Name** (Last, First, M.I.) | Sex (M/F) | **Birthdate** (MM/DD/YYYY) / / |
|---|---|---|---|

| **Social Security Number** (if dependent has no SSN, write "None") | Other Medical Coverage **Yes*** ☐ | Other Rx Drug Coverage **Yes*** ☐ | Physically or Mentally Disabled **Yes** ☐ | Primary Medical Office ID Number | Current Patient **Yes** ☐ |
|---|---|---|---|---|---|

| (A)dd (C)hange ____ (R)emove | **4. Child Name** (Last, First, M.I.) | Sex (M/F) | **Birthdate** (MM/DD/YYYY) / / |
|---|---|---|---|

| **Social Security Number** (if dependent has no SSN, write "None") | Other Medical Coverage **Yes*** ☐ | Other Rx Drug Coverage **Yes*** ☐ | Physically or Mentally Disabled **Yes** ☐ | Primary Medical Office ID Number | Current Patient **Yes** ☐ |
|---|---|---|---|---|---|

| (A)dd (C)hange ____ (R)emove | **5. Child Name** (Last, First, M.I.) | Sex (M/F) | **Birthdate** (MM/DD/YYYY) / / |
|---|---|---|---|

| **Social Security Number** (if dependent has no SSN, write "None") | Other Medical Coverage **Yes*** ☐ | Other Rx Drug Coverage **Yes*** ☐ | Physically or Mentally Disabled **Yes** ☐ | Primary Medical Office ID Number | Current Patient **Yes** ☐ |
|---|---|---|---|---|---|

| (A)dd (C)hange ____ (R)emove | **6. Child Name** (Last, First, M.I.) | Sex (M/F) | **Birthdate** (MM/DD/YYYY) / / |
|---|---|---|---|

| **Social Security Number** (if dependent has no SSN, write "None") | Other Medical Coverage **Yes*** ☐ | Other Rx Drug Coverage **Yes*** ☐ | Physically or Mentally Disabled **Yes** ☐ | Primary Medical Office ID Number | Current Patient **Yes** ☐ |
|---|---|---|---|---|---|

**1.** If "Yes" to **Other Medical Coverage** above, provide effective dates, name & policy number of insurance carrier, HMO, or other source & your **Member Identification Number**.

**2.** If "Yes" to **Other Rx Drug Coverage** above, provide effective dates, name & policy number of insurance carrier, HMO, or other source & your **Member Identification Number**.

**3.** Does any dependent listed above live at a different address than the employee? ☐ Yes ☐ No If "Yes," who & what address? Briefly explain circumstances.

**4.** Is your spouse employed? ☐ Yes ☐ No If "Yes," provide name & address of spouse's employer.

## Conditions of Enrollment

**NOTICE: California law prohibits an HIV test from being required or used by health insurance companies as a condition of obtaining health insurance coverage.**

### Applicant Acknowledgments and Agreements

On behalf of myself and the dependents listed on Pages 1 and 2, I agree to or with the following:

1. I acknowledge that by enrolling in the following plans, coverage is provided by Aetna Health of California Inc. (referred to as "Aetna").
2. I authorize deductions from my earnings for any contributions required for coverage and I agree to make any necessary payments as required for coverage.
3. The plan documents (Schedule of Benefits, Group Agreement, Evidence of Coverage, amendments, riders or endorsements) will determine the rights and responsibilities of member(s) and will govern in the event they conflict with any benefits comparison, summary or other description of the plan.
4. I understand and agree that, with the exception of Aetna Rx Home Delivery®, Aetna Health of California Inc.'s participating providers, including all participating primary care physicians, are independent contractors and are neither agents nor employees of Aetna Health of California Inc. Aetna Rx Home Delivery, LLC, is a subsidiary of Aetna Life Insurance Company. The availability of any particular provider cannot be guaranteed and provider network composition is subject to change. Notice of the change shall be provided in accordance with applicable state law.
5. I understand and agree that, with certain exceptions described in the plan documents, HMO plans only provide coverage for referred benefits, and that, in order to be covered, services must be performed either by a participating primary care physician, or by the participating specialist, hospital, pharmacy, dentist, or other provider as authorized by a referral from a participating primary care physician.

## Misrepresentation

**Attention California Residents: For your protection, California law requires notice of the following to appear on this form:** Any person who knowingly presents a false or fraudulent claim for the payment of a loss is guilty of a crime and may be subject to fines and confinement in state prison.

To the best of my knowledge, I represent that all information supplied in this form is true and complete. I have read and agree to the Conditions of Enrollment and Misrepresentation on this **California** Employee Enrollment/Change Request form.

**NOTICE OF BINDING ARBITRATION: ANY DISPUTE ARISING FROM OR RELATED TO HEALTH PLAN MEMBERSHIP MAY BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION, AND NOT BY A LAWSUIT OR RESORT TO COURT PROCESS EXCEPT AS CALIFORNIA LAW PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. THE AGREEMENT TO ARBITRATE INCLUDES, BUT IS NOT LIMITED TO, DISPUTES INVOLVING ALLEGED PROFESSIONAL LIABILITY OR MEDICAL MALPRACTICE, THAT IS, WHETHER ANY MEDICAL SERVICES COVERED BY THIS AGREEMENT WERE UNNECESSARY OR WERE UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED. THE HEALTH PLAN AGREEMENT ALSO LIMITS CERTAIN REMEDIES AND MAY LIMIT THE AWARD OF PUNITIVE DAMAGES. SEE THE EVIDENCE OF COVERAGE FOR FURTHER INFORMATION.**

**I understand that I am giving up the constitutional right to have disputes decided in a court of law before a jury, and instead am accepting the use of binding arbitration. This means that members will not be able to try their case in court. I further understand that the Health Plan agreement contains limitations on certain remedies and that there may be certain limitations to the recovery of punitive damages.**

***If you have questions concerning the benefits provided by or excluded under this Agreement, contact a Member Services representative at 1-800-323-9930 before signing this form.***

| ***Employee Signature*** *- Required* | ***Date (Month/Day/Year)*** | ***Employee E-mail Address (optional)*** | ***Primary Language Spoken*** |
|---|---|---|---|
| **X** | / / | | |

## Employer Verification (To Be Completed by Employer)

| ***Employer Signature*** *- Required* | ***Title*** | ***Date (Month/Day/Year)*** |
|---|---|---|
| **X** | | / / |

## Instructions

### Employer

- Complete the **Employer Group Information** at the top of Page 1.
- Complete the **Employer Verification** below the Employee signature on Page 3. Employer must sign & date the Enrollment/Change Request for new enrollments or coverage changes to be processed.

### Employee – Complete Sections A – D.

**Section A – Type of Activity:**

- Check box(es) indicating reason(s) for submitting this Enrollment/Change Request.
- Provide Effective Date(s) & Date of Event(s) where requested.

**Section B – Employee Information:** Complete all information in order for your Enrollment/Change Request to be processed.

**Section C – Plan Options:**

- Your selection(s) must be offered by your employer.
- Check *one* Plan Option box, indicate Plan Option Name (where applicable) & check *one* Primary Copay.

**Section D – Individuals Covered:**

- Add/Change/Remove – Use "A", "C", or "R" to indicate whether you are adding, changing or removing coverage for an individual.
- Print your full name along with the names(s) of your dependent(s), if applicable. Indicate Sex, Birthdate, & Social Security Number for each individual listed.
- If you or your dependent(s) have **Other Medical Coverage**, check the "Yes" box and provide beginning & ending effective dates, name & policy number of insurance carrier, HMO or other source & your **Member Identification Number** for the insurance plan in the space provided in Number 1.
- If you or your dependent(s) have **Other Rx Drug Coverage**, check the "Yes" box and provide beginning & ending effective dates, name & policy number of insurance carrier, HMO or other source & your **Member Identification Number** for the insurance plan in the space provided in Number 2.
  - **NOTE:** In some instances your medical carrier will differ from your Rx drug carrier.
- If a dependent is Physically or Mentally Disabled & financially dependent, check "Yes" & provide proof of physical or mental disability status from the attending physician.
- **Primary Medical Office ID Number:** Locate the office ID number for the primary care physician (if applicable) from the appropriate provider directory or from DocFind®, Aetna's online provider directory at "www.aetna.com".
- If you are a current patient, please check the "Yes" box under Current Patient.

**Conditions of Enrollment/Misrepresentation – Employee Signature:** Employee must sign & date the Enrollment/Change Request for new enrollments or coverage changes to be processed.

## DMHC Written Notice of Availability of Language Assistance

HMO and DMO-based plans - **IMPORTANT:** Can you read this letter? If not, we can have somebody help you read it. You may also be able to get this letter written in your language. For free help, please call right away at 1-877-287-0117.

Planes basados en DMO y HMO - **IMPORTANTE:** ¿Puede leer esta carta? En caso de no poder leerla, le brindamos nuestra ayuda. También puede obtener esta carta escrita en su idioma. Para obtener ayuda gratuita, por favor llame de inmediato al 1-877-287-0117.